ARIZONA DEPARTMENT OF ECONOMIC SECURITY
DIVISION OF DEVELOPMENTAL DISABILITIES
UNIFORM BILLING DOCUMENT (Short Form) (rev April 2007)

2a. PROVIDER NPI NUMBER:_________________________

3. PROVIDER OF SERVICE AHCCCS ID# (THERAPIES ONLY): _______________ PAGE _______ OF _______

1. PROVIDER NAME: ______________________

4. MONTH/YEAR OF SERVICE: ______________

6. CONTRACT #: ______________________

2. FEI / SSN: ______________________

5. SERVICE: ______________________

7. District: I II III IV V VI VII VIII

8 PROV LOC	9 ASSISTS CLIENT ID	10 CLIENT NAME (LAST)	11 CLIENT NAME (FIRST)	12 SVC START DATE	13 SVC END DATE	14 SVC CODE	15 POS	16 DEL UNITS	17 NO SHOW/ ABSENT UNITS	18 TOTAL UNITS	19 RATE	20 TPL CODE	21 TPL AMT	22 TOTAL	23 SITE RATE COUNT	24 BUDGET SOURCE CODE

25. TOTAL: ________

26. I certify that the information contained in this billing document is true and correct and has been prepared in accordance with the terms of the contract.

PREPARER'S SIGNATURE & DATE

PREPARER'S NAME & TELEPHONE NUMBER

27. $ ______________________
TOTAL BILLING AMOUNT SUBMITTED UNDER THIS INVOICE

PROVIDER'S SIGNATURE & DATE

PROVIDER'S NAME & TELEPHONE NUMBER

DDD SIGNATURE & DATE PROCESSED

CLAIM #: ____________ CLAIM #: ____________ CLAIM #: ____________